STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	09/15/2011

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MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN46637

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: 9/13, 9/14, 9/15, 2011 Facility number: 004732 Provider number: 155752 AIM number: 200808300 Survey team: Vicki Manuwal, RN, TC Bobbie Costigan, RN Sandra Haws, RN Census bed type: SNF: 3 NF: 24 Residential: 12 Total: 39 Census payor type: Medicare: 3 Medicaid: 24 Other: 12 Total: 39 Sample: 10 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review 9/22/11 by Suzanne Williams, RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the physician of blood sugar results that fell within call parameters for 1 of 4 diabetic residents reviewed for diabetic call orders in a sample of 10.	F0157	F157- The facility will inform physician, family and/or legal representative when blood sugar results are not within parameters. Resident #26 blood sugars have been reviewed and have been found to be within parameters.	10/03/2011

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	Resident # 26 Findings include: 1. The clinical record for Resident # 26, reviewed on 9/14/11 at 9:50 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and dementia. A Physician Order, dated 3/23/11, indicated, "...BS (blood sugar)...> (greater than) 400 call MD..." Review of the August 2011, "Diabetic Monitoring Flow Sheet", indicated the following two blood sugars that fell above call parameters: 8/4/11 4:00 P.M. Accu Check 408. 8/17/11 6:00 P.M. Accu Check 408. The clinical record lacked documentation of physician notification. Resident # 26's care plan, dated 12/23/10, indicated, "...Notify MD c (with) complications of hypo (low)/hyperglycemia (high blood sugar)..." During interview on 9/15/11 at 11:05 A.M., the DON indicated she is aware of		The physician has been notified of the discrepancies identified during the survey. No new orders noted. Staff have been in-serviced on monitoring of blood sugars and proper protocol for follow up. Diabetic Flow Sheet has been initiated for easy review by staff. Mangers are monitoring documentation at least daily to ensure continued compliance by staff. Other resident records have been reviewed to ensure no negative outcome and proper notification. No issues noted. Audits will be conducted daily in the first 3 months by Director of Nursing or designee. The QA committee will review findings to determine if audits can be suspended, If consistent compliance is met for the quarter, then audits will be performed once a week by Director of Nursing or designee	

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	errors related to sliding scale and lack of physician notification. A facility policy untitled, undated, provided by the DON on 9/15/11 at 11:00 A.M., indicated, "...Notify physician in accordance with call orders..." 3.1-5(a)(2)			
F0223 SS=A	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from verbal abuse for 1 of 10 residents reviewed for abuse in a sample of 10. Resident: # 11 Findings include: Resident #11's record was reviewed on 9/14/11 at 9:00 a.m. The resident's record indicated diagnoses of, but not limited to; dementia, obesity, and diabetes. The resident's quarterly MDS (Minimum Data Set) assessment dated 7/7/11 indicated the resident's cognition was moderately impaired.	F0223	The Facility will ensure that all residents are free from verbal abuse. The incident was reported to ISDH within 24 hours. CNA # 2 was suspended immediately and then terminated. No other residents were effected by this deficiency. All staff have been in-serviced on abuse and neglect policy. Administrator and DON or designee will monitor staff daily to ensure that residents are free from any abuse. All investigations will be reviewed by DON and Administrator or designee The results of all investigations in regards of resident abuse will be reported monthly to QA committee. Additional plan of correction will be implemented as needed based	10/03/2011

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	An abuse allegation was reported by the facility to Indiana State Department of Health on 10/20/11 at 8:58 a.m. The abuse incident occurred on 10/19/10 at 12:30 p.m. and involved CNA # 2 and Resident # 11. The incident report completed by the Director of Nursing indicated "while (CNA #2) had resident (name) on the toilet she stated 'I am sick and tired of your fat a_ _ pi_ _ ing on yourself.' This was witnessed by two other staff members." During an interview with the Director of Nursing on 9/14/11 at 10:00 a.m., she indicated the CNA was suspended immediately and then terminated because the comment was heard by another staff member. She indicated the other staff that heard the comment was the activity staff # 3. During an interview with the activity staff # 3 on 9/14/11 at 10:30 a.m., she indicated Resident # 11 had become wet from being incontinent so she let CNA #2 know the resident needed toileted and changed. She further indicated she was able to hear the comment CNA # 2 made to the resident. Activity staff # 3 indicated she reported the incident to the Director of Nursing immediately.		on the results of the investigations. Administrator and Director of Nursing or designee will continue to monitor daily the staff to ensure that residents are free from any abuse.	

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A statement recorded and signed by the activity staff # 3 undated indicated " (CNA # 2) (name) got mad because (Resident # 11) (name) was wet. She stated 'I'm sick of her fat a_ _ pi_ _ ing on herself.' There were other people who heard this besides me." Signed by activity staff # 3.

A statement recorded and signed by CNA # 4 on 10/19/10 indicated "I was in the batheroom (sic) with (CNA # 2) (name) and (Resident #11) when she said I'm tired of you pi_ _ ing on yourself."

Review of CNA # 2's employee record on 9/15/11 at 9:00 a.m. indicated she had been inserviced on the facility's policy on resident rights and abuse and neglect on 6/2/10 when hired.

The facility's policy titled "Abuse Prevention and Reporting Policy" reviewed on 9/15/11 at 10:00 a.m. indicated "It is the policy of (facility name) to protect residents and staff from abusive acts and to adequately train facility personnel in methods of detection and prevention of abuse. (Facility name) will comply with state and federal regulations for reporting suspected or actual acts...Abuse. Verbal- Refers to any use of oral, written, or gestured language

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	that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents in a negative manner, regardless of their age, ability to comprehend, or disability. Use of vulgar language in a resident's presence or hearing range...." Although the facility followed their abuse and neglect policy, by staff immediately reporting the incident, CNA #2 was suspended, the incident was reported to ISDH within 24 hours, an investigated of the incident was completed and the employee was terminated. 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure injuries of unknown origin were thoroughly and completely investigated and in accordance with the facility's policy for 1 of 3	F0225	F225 - The facility will ensure that injuries of unknown origin are investigated thoroughly. Resident # 43 has expired since incident occurred 7 months ago. Other investigations have been	10/03/2011

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	residents reviewed for injuries in a sample of 10. Resident # 43 Findings include: 1. The closed clinical record for Resident # 43, reviewed on 9/15/11 at 9:20 A.M., indicated diagnoses of, but not limited to: right ulna fracture, end stage renal disease, and dementia. A facility "Incident/Accident Report," indicated, "...2/13/11 1:45 P.M....R (right) wrist edema (swelling)...Called to RM (room) by CNA (certified nursing assistant). Res (resident) up in W/C (wheel chair) c/o (complaining of) R wrist pain. 0 (no) break in skin, 0 bruising noted. General edema noted to R wrist. 0 fall or incident...Res screaming c (with) finger touch to R wrist..." Review of a "Facility Incident Reporting Form," indicated, "...Faxed to ISDH (Indiana State Department of Health)...2/14/11 @ (at) 12:40 P.M....Incident Time: 2/13/11 @ 1:45 P.M....Resident complained of R wrist pain, had pain c palpation (touch), edema to wrist, no bruising....Staff being interviewed....Initial Report..."		reviewed to ensure thorough and complete investigations have occurred. No new issues noted. Staff and Management Team have been in-serviced on incident and accident policy and the necessity to investigate all incidents thoroughly. Report protocol has been in-serviced as well. All investigations will be reviewed by DON or designee and Administrator to ensure continued thoroughness in investigation protocol. All incidents will be reviewed and reported to QA to continue monitoring and compliance. The results of all investigations regards of injuries of unknown origin will be reported monthly to QA committee. Additional plan of correction will be implemented as needed based on the results of the investigations.	

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	Further review of another "Facility Incident Reporting Form," undated, indicated, "...Faxed to ISDH...2/18/11 @ 12:40 P.M....Staff Involved (Name) (LPN # 20)...Resident c/o R wrist pain on 2/13/11, edema & pain noted. Resident was sent to E.R. (emergency room). After completion of investigat (sic) & staff interviews c CNA's, CNA on duty 2/13/11 on 11 p (P.M.) to 7 a (A.M.) shift stated reside (sic) (Resident # 43) was found on floor next to bed on fall mat & she reported to nurse on duty. Right ulnar fracture....Nurse on duty 2/13/11 for 11 p to 7 a shift suspended after completion on investigation for not reporting incident & not following facility policy, & terminated for not reporting & not following facility policy...." Review of a written statement from LPN # 20, dated 2/13/11 11:50 P.M., indicated, "...No report of c/o pain or discomfort were reported to me by staff or resident herself for 11-7 (11 P.M. to 7 A.M.) 2/12/11 to 2/13/11. When resident was sitting in cafe area in W/C (after) getting up for day - she only talked of finding bed or going back to bed. There were no signs of discomfort or pain." A written statement from CNA # 17, dated 2/13/11, indicated, "...(Resident # 43) was complaining about her arm on 2/12/11.			

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	She said men did something to it but she wasn't showing any pain. She just started talking about some men, but she appeared to be fine. She didn't show any sign of pain when we dressed her." Review of a written statement from CNA # 21, dated 2/13/11, indicated, "... (Resident # 43) was complaining of some men doing something to her but complained of no pain and wasn't showing any signs of such. She was fine during getup (sic). She just kept saying she was ready to get out of bed." A facility "Corrective Action Form," dated 2/16/11, indicated, "...(LPN # 20)...Fall being investigated that wasn't documented, resulted in fracture?...Suspended pending investigation 2/16. 2/18/11 After completion of investigation Nurse (sic) terminated 2 (secondary) (sic) not reporting incident & not following company policies..." Review of the "Skilled Daily Nurses Note," indicated, "...2/13/11 5:45 A.M. Rested thru noc (night) s (without) S/S (signs & symptoms) discomfort. Compliant c staff during care (LPN # 20)....2/13/11 1:45 P.M. Called to RM by CNA, family at bedside (Daugh) (daughter). Res c/o R wrist pain upon			

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	palpation even to finger tip touch. Edema noted to wrist, 0 bruising noted. 0 known injury this shift. Interviewed staff, staff states she has had no c/o of (sic) pain all day until daugh arrived....ER (emergency room) eval (evaluation) R wrist pain....2/13/11 8:00 P.M. Resident returned...with ulnar fracture....Res in Rt (right) wrist splint...2/14/11 7:15 A.M. R wrist splint intact....No S/S discomfort/pain noted....(LPN # 20)...2/16/11 8:30 A.M. Rested thru noc s S/S discomfort et (and) no c/o voiced (sic). R wrist splint dry/intact....some swelling to tips of fingers noted. No discoloration noted...." Review of Resident # 43's quarterly MDS (Minimum Data Set), dated 8/11/11, indicated, "...Cognition - unable to determine..." A "ER Physician Report," dated 2/13/11, indicated, "...presents to the emergency department with right wrist deformity. This was noticed by the patient's daughter at the extended-care facility, it is unclear if the patient had a recent trauma, although she did have a fall several weeks ago....The right wrist in the ulnar aspect there is a deformity and there is visible swelling. It is very minimally tender....X-ray of the right wrist, there is a distal ulna fracture with some			

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	displacement...." Review of the clinical schedule from February 1st through February 13th, 2011, indicated one male CNA was scheduled for the 3 P.M. to 11 P.M. shift. The "Daily Staffing Sheet" indicated the CNA did report for the scheduled shifts. On 9/14/11 at 4:00 P.M., the Administrator indicated the facility investigates all accidents. Interview with the DON on 9/15/11 at 11:05 A.M., she indicated she checked the schedule for the night in question, but only female CNA's were working that night. She further indicated she should have done a more thorough investigation of the incident. On 9/15/11 at 11:30 A.M., the DON indicated LPN # 20 lied about the incident and did not document or report the fall. She further indicated she was more concerned about the fall and not the "men" statement. During interview on 9/15/11 at 11:30 A.M., CNA # 17, with the DON present, indicated she heard Resident # 43's alarm going off. She stated she found Resident # 43 on the floor mat and immediately reported it to LPN # 20. She further			

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	indicated LPN # 20 told her to not document the fall. She indicated she did not report the fall or LPN # 20's statement to anyone else. Interview on 9/15/11 at 12:00 P.M., CNA # 17 indicated she heard Resident # 43's alarm sounding and found Resident # 43 sitting up on her floor mat. She indicated Resident # 43 was not complaining of pain. She further indicated she went and got LPN # 20. LPN # 20 and CNA # 17 returned to Resident # 43's room and returned her to her bed. She indicated LPN# 20 was checking Resident # 43 over. She indicated she reported the fall to only LPN # 20, and LPN # 20 said, don't worry about it. She further indicated she wrote her statement the next day about the arm but didn't not relate the fall to the arm pain. She indicated LPN # 20 didn't exactly tell her to not document the fall but told her don't worry about it. Review of a facility policy titled "Abuse Prevention and Reporting Policy", undated, indicated, "...Any staff member who...has knowledge a resident has sustained a physical injury which is not reasonably explained by the history of injuries...is required to make an immediate oral report to the Administrator, Director of Nursing, their supervisor and Social Services Director, if			

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	appropriate....Complaints of abuse by a resident...shall be promptly addressed by the nurse on duty...All unknown injuries...will be investigated per protocol to eliminate any question of abuse...." 3.1-28(a) 3.1-28(d)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their written protocol regarding alleged abuse and injuries of unknown origin for 1 of 7 residents reviewed for abuse and neglect in a sample of 10. Resident # 43 Findings include: 1. Review of a facility policy titled "Abuse Prevention and Reporting Policy", undated, indicated, "...Any staff member who...has knowledge a resident has sustained a physical injury which is not reasonably explained by the history of injuries...is required to make an immediate oral report to the Administrator, Director of Nursing, their supervisor and Social Services Director, if	F0226	F226 - The facility will ensure that alleged abuse and injuries of unknown origin are investigated thoroughly. Resident # 43 has expired since incident occurred 7 months ago. Other investigations have been reviewed to ensure thorough and complete investigations have occurred. No new issues noted. Staff and Management Team have been in-serviced on abuse and incident and accident policy and the necessity to investigate all incidents thoroughly. Report protocol has been in-serviced as well. All investigations will be reviewed by DON or designee and Administrator or designee to ensure continued thoroughness in investigation protocol. All incidents will be reviewed and reported to QA to continue monitoring and compliance. The results of all investigations in regards of resident abuse and injuries of unknown origin will	10/03/2011

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	155752	A. BUILDING 00 B. WING	09/15/2011

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	appropriate....Complaints of abuse by a resident...shall be promptly addressed by the nurse on duty...All unknown injuries...will be investigated per protocol to eliminate any question of abuse...." The closed clinical record for Resident # 43, reviewed on 9/15/11 at 9:20 A.M., indicated diagnoses of, but not limited to: right ulna fracture, end stage renal disease, and dementia. A facility "Incident/Accident Report," indicated, "...2/13/11 1:45 P.M....R (right) wrist edema (swelling)...Called to RM (room) by CNA (certified nursing assistant). Res (resident) up in W/C (wheel chair) c/o (complaining of) R wrist pain. 0 (no) break in skin, 0 bruising noted. General edema noted to R wrist. 0 fall or incident...Res screaming c (with) finger touch to R wrist..." Review of a "Facility Incident Reporting Form," indicated, "...Faxed to ISDH (Indiana State Department of Health)...2/14/11 @ (at) 12:40 P.M....Incident Time: 2/13/11 @ 1:45 P.M....Resident complained of R wrist pain, had pain c palpation (touch), edema to wrist, no bruising....Staff being interviewed....Initial Report..." Further review of another "Facility		be reported every 3 months to QA committee. Additional plan of correction will be implemented as needed based on the results of the investigations. Administrator and Director of Nursing will continue to monitor daily the staff to ensure that residents are free from any abuse and injuries.	

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	Incident Reporting Form," undated, indicated, "...Faxed to ISDH...2/18/11 @ 12:40 P.M....Staff Involved (Name) (LPN # 20)...Resident c/o R wrist pain on 2/13/11, edema & pain noted. Resident was sent to E.R. (emergency room). After completion of investigat (sic) & staff interviews c CNA's, CNA on duty 2/13/11 on 11 p (P.M.) to 7 a (A.M.) shift stated reside (sic) (Resident # 43) was found on floor next to bed on fall mat & she reported to nurse on duty. Right ulnar fracture....Nurse on duty 2/13/11 for 11 p to 7 a shift suspended after completion on investigation for not reporting incident & not following facility policy, & terminated for not reporting & not following facility policy...." Review of a written statement from LPN # 20, dated 2/13/11 11:50 P.M., indicated, "...No report of c/o pain or discomfort were reported to me by staff or resident herself for 11-7 (11 P.M. to 7 A.M.) 2/12/11 to 2/13/11. When resident was sitting in cafe area in W/C (after) getting up for day - she only talked of finding bed or going back to bed. There were no signs of discomfort or pain." A written statement from CNA # 17, dated 2/13/11, indicated, "...(Resident # 43) was complaining about her arm on 2/12/11. She said men did something to it but she			

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	wasn't showing any pain. She just started talking about some men, but she appeared to be fine. She didn't show any sign of pain when we dressed her." Review of a written statement from CNA # 21, dated 2/13/11, indicated, "... (Resident # 43) was complaining of some men doing something to her but complained of no pain and wasn't showing any signs of such. She was fine during getup (sic). She just kept saying she was ready to get out of bed." A facility "Corrective Action Form," dated 2/16/11, indicated, "...(LPN # 20)...Fall being investigated that wasn't documented, resulted in fracture?...Suspended pending investigation 2/16. 2/18/11 After completion of investigation Nurse (sic) terminated 2 (secondary) (sic) not reporting incident & not following company policies..." On 9/14/11 at 4:00 P.M., the Administrator indicated the facility investigates all accidents. Interview with the DON on 9/15/11 at 11:05 A.M., she indicated she checked the schedule for the night in question, but only female CNA's were working that night. She further indicated she should			

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	have done a more thorough investigation of the incident. On 9/15/11 at 11:30 A.M., the DON indicated LPN # 20 lied about the incident and did not document or report the fall. She further indicated she was more concerned about the fall and not the "men" statement. During interview on 9/15/11 at 11:30 A.M., CNA # 17, with the DON present, she stated she found Resident # 43 on the floor mat and immediately reported it to LPN # 20. She further indicated LPN # 20 told her to not document the fall. She indicated she did not report the fall or LPN # 20's statement to anyone else. Interview on 9/15/11 at 12:00 P.M., CNA # 17 indicated she found Resident # 43 sitting up on her floor mat. She further indicated she went and got LPN # 20. She indicated she reported the fall to only LPN # 20, and LPN # 20 said don't worry about it. She further indicated she wrote her statement the next day about the arm but didn't not relate the fall to the arm pain. She indicated LPN # 20 didn't exactly tell her to not document the fall but told her don't worry about it. 3.1-28(a)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician orders were followed related to blood sugars and administration of insulin coverage for 2 of 4 residents reviewed for diabetes in a sample of 10. Resident # 26, # 40 Findings include: 1. The clinical record for Resident # 26, reviewed on 9/14/11 at 9:50 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and dementia. A Physician Order, dated 3/23/11, indicated, "...Accu Check (blood sugar test) before meals and at bedtime...Novolin R (insulin)...sliding scale...BS (blood sugar) < (less than) 250=0 units; 251-400=8 units; > (greater than) 400=12 units; > 400 call MD..." Review of the June, 2011, "Diabetic Monitoring Flow Sheet", indicated incorrect sliding scale coverage for the following four Accu Checks:	F0282	F282 – The facility will follow physician orders. Resident #26 and #40 have had a complete audit of records to ensure compliance with physician orders. Physician has been notified of discrepancies identified during survey. No new orders noted. Other residents with accu-checks have had a review of medical records to verify compliance with physician orders related to blood sugars. No issues identified. Nurses have been in-serviced on proper protocol after accu-checks. New diabetic flow sheets have been implemented to ensure continued compliance. Audits are performed at least daily by DON designee. Results of audits will be reported to QA to ensure continued compliance. Audits will be conducted daily for the first 3 months by Director of Nursing or designee. The QA committee will review findings to determine if audits can be suspended, If consistent compliance is met for quarter. Than audits will be performed once a week by Director of Nursing or designee.	10/03/2011

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	6/17/11 6:00 A.M. - Accu Check 479. No coverage documented; should have received 12 units. Next available Accu Check 6/17/11 12:00 P.M. - 201. 6/17/11 6:00 P.M. - Accu Check 249. Given 8 units; should have received 0 units. Next available Accu Check 6/17/11 9:00 P.M. - 402. 6/24/11 5:00 P.M. - Accu Check 400. Given 12 units; should have received 8 units. Next available Accu Check 6/24/11 9:00 P.M. - 118. 6/28/11 6:00 P.M. - Accu Check 236. Given 8 units; should have received 0 units. Next available Accu Check 6/28/11 9:00 P.M. - 161. Review of the July, 2011, "Diabetic Monitoring Flow Sheet", indicated incorrect sliding scale coverage for the following five Accu Checks: 7/7/11 9:00 P.M. - Accu Check both 372 & 317 documented. No coverage documented; should have received 8 units. Next available Accu Check 7/8/11 6:00 A.M. - 92. 7/12/11 9:00 P.M. - Accu Check 316. No coverage documented; should have received 8 units. Next available Accu			

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	Check 7/13/11 6:00 A.M. - 142. 7/14/11 6:00 P.M. - Accu Check 337. No coverage documented; should have received 8 units. Next available Accu Check 7/14/11 9:00 P.M. - 216. 7/15/11 6:00 A.M. - Accu Check 416. Given 8 units; should have received 12 units. Next available Accu Check 7/15/11 12:00 P.M. - 242. 7/15/11 6:00 P.M. - Accu Check 400. Given 10 units; should have received 8 units. Next available Accu Check 7/15/11 9:00 P.M. - 216. Review of the August, 2011, "Diabetic Monitoring Flow Sheet", indicated incorrect sliding scale coverage for the following Accu Check: 8/13/11 12:00 P.M. - Accu Check 324. No coverage documented; should have received 8 units. Next available Accu Check 8/13/11 6:00 P.M. - 224. Resident # 26's care plan, dated 12/23/10, indicated, "...Administer insulin & oral medication as ordered..." During interview with the DON on 9/15/11 at 11:05 A.M., she indicated she is now aware of the multiple sliding scale			

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	errors. She further indicated she checked the blood sugar monitoring tool for completeness but not accuracy of the dosage given because she assumed every nurse should know how to do sliding scale. 2. The clinical record for Resident # 40, reviewed on 9/14/11 at 11:30 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hyperthyroidism, and peripheral neuropathy. A Physician Order, dated 5/27/11, indicated, "...Accu Check (blood sugar test) AC (before meals) & HS (bedtime)...Novolin R (insulin)...sliding scale...BS (blood sugar) < (less than) 150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; > (greater than) 400=12 units; and call MD..." Review of the July, 2011, "Diabetic Monitoring Flow Sheet", indicated incorrect sliding scale coverage for the following 11 Accu Checks: 7/3/11 9:00 P.M. - Accu Check 220. Given 6 units; should have received 4 units. Next available Accu Check 7/4/11 12:00 P.M. - 320. 7/4/11 12:00 P.M. - Accu Check 320.			

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	Given 10 units; should have received 8 units. Next available Accu Check 7/4/11 6:00 P.M. - 232. 7/5/11 12:00 P.M. - Accu Check 218. Given 2 units; should have received 4 units. Next available Accu Check 7/5/11 6:00 P.M. - 286. 7/8/11 6:00 P.M. - Accu Check 230. No coverage documented; should have received 4 units. Next available Accu Check 7/8/11 9:00 P.M. - 282. 7/14/11 6:00 P.M. - Accu Check 332. No coverage documented; should have received 8 units. Next available Accu Check 7/14/11 9:00 P.M. - 266. 7/14/11 9:00 P.M. - Accu Check 266. No coverage documented; should have received 6 units. Next available Accu Check 7/15/11 6:00 A.M. - 94. 7/15/11 12:00 P.M. - Accu Check 198. No coverage documented; should have received 2 units. Next available Accu Check 7/15/11 6:00 P.M. - 217. 7/16/11 9:00 P.M. - Accu Check 181. No coverage documented; should have received 2 units. Next available Accu Check 7/17/11 6:00 A.M. - 162.			

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	7/17/11 6:00 P.M. - Accu Check 347. Given 10 units; should have received 8 units. Next available Accu Check 7/17/11 9:00 P.M. - 235. 7/19/11 6:00 P.M. sic (9:00 P.M.) - Accu Check 284. No coverage documented; should have received 6 units. Next available Accu Check 7/20/11 6:00 A.M. - 86. 7/20/11 9:00 P.M. - Accu Check 264. Given 8 units; should have received 6 units. Next available Accu Check 7/21/11 6:00 A.M. - 79. Review of the August, 2011, "Diabetic Monitoring Flow Sheet", indicated incorrect sliding scale coverage for the following eight Accu Checks: 8/1/11 9:00 P.M. - Accu Check 343. Given 10 units; should have received 8 units. Next available Accu Check 8/2/11 6:00 A.M. - 96. 8/8/11 9:00 P.M. - Accu Check 358. Given 8 units; should have received 10 units. Next available Accu Check 8/9/11 6:00 A.M. - 102. 8/9/11 6:00 P.M. - Accu Check 292. No coverage documented; should have received 6 units. Next available Accu			

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	Check 8/10/11 6:00 A.M. - 94. 8/15/11 9:00 P.M. - Accu Check 338. No coverage documented; should have received 8 units. Next available Accu Check 8/16/11 6:00 A.M. - 95. 8/20/11 12:00 P.M. - Accu Check 245. Given 6 units; should have received 4 units. Next available Accu Check 8/20/11 6:00 P.M. - 254. 8/22/11 12:00 P.M. - Accu Check 250. Given 2 units; should have received 4 units. Next available Accu Check 8/22/11 6:00 P.M. - 279. 8/30/11 9:00 P.M. - Accu Check 319. Given 6 units; should have received 8 units. Next available Accu Check 8/31/11 6:00 A.M. - 79. Review of the September 1st through 11th, 2011, "Diabetic Monitoring Flow Sheet", indicated incorrect sliding scale coverage for the following Accu Check: 9/3/11 9:00 P.M. - Accu Check 345. Given 10 units; should have received 8 units. Next available Accu Check 9/4/11 6:00 A.M. - 150. Resident # 40's care plan, dated 7/12/11, indicated, "...Administer meds as			

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	ordered...." During interview with the DON on 9/15/11 at 11:05 A.M., she indicated she is now aware of the multiple sliding scale errors. She further indicated she checked the blood sugar monitoring tool for completeness but not accuracy of the dosage given because she assumed every nurse should know how to do sliding scale. A facility policy, untitled, undated, provided by the DON on 9/15/11 at 11:00 A.M., indicated, "...The resident is on the sliding scale....The resident's dosage will be determined by blood glucose parameters as ordered by the physician. 3.1-35(g)(2)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure the resident's clinical record was accurate, complete,	F0514	F514 – The facility will maintain clinical records in accordance with accepted professional standards. Nurses identified to	10/03/2011

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	and legible for 2 of 10 residents whose clinical records were reviewed in a sample of 10. Resident # 26, # 40 Findings include: 1. The clinical record for Resident # 26, reviewed on 9/14/11 at 9:50 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and dementia. A Physician Order, dated 3/23/11, indicated, "...Accu Check (blood sugar test) before meals and at bedtime..." Review of the June, 2011, "Diabetic Monitoring Flow Sheet", indicated incorrect sliding scale coverage for the following four Accu Checks: 6/17/11 6:00 A.M. - Accu Check 479. No coverage documented; should have received 12 units. Review of the July, 2011, "Diabetic Monitoring Flow Sheet", lacked documentation of the amount of coverage given for the following three Accu Checks: 7/7/11 9:00 P.M. - Accu Check both 372		have problems with documentation or legibility have been disciplined. Resident #26, and #40 have had a review of records to ensure legibility and accuracy in administration of blood sugars. All resident records have been reviewed to ensure compliance with clinical records policy. In-services have been completed with applicable staff. All diabetic flow sheet entries, signatures, documentation and signatures in the nurses' notes is to be accurate, complete and legible. Audits are performed at leat daily by DON or designee. Results of audits will be reported to QA to ensure continued compliance. Audits will be conducted daily in the first 3 months by Director of Nursing or designee. The QA committee will review findings to determine if audits can be suspended. If consistent compliance is met for quarter. Than audits will be performed once a week by Director of Nursing or designee.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	& 317 documented. No coverage documented. 7/12/11 9:00 P.M. - Accu Check 316. No coverage documented. 7/14/11 6:00 P.M. - Accu Check 337. No coverage documented. Review of the August, 2011, "Diabetic Monitoring Flow Sheet", a lack of testing one time and lacked documentation of the amount of coverage given for the following one Accu Check: 8/7/11 6:00 A.M. - No testing documented. 8/13/11 12:00 P.M. - Accu Check 324. No coverage documented. Review of Resident # 26's care plan, dated 12/23/10, indicated, "...11. Accu Check as ordered by MD..." During interview with the DON on 9/15/11 at 11:05 A.M., she indicated she is now aware of the missing documentation and/or lack of testing. She further indicated she checks the blood sugar monitoring tool for completeness. 2. The clinical record for Resident # 40, reviewed on 9/14/11 at 11:30 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hyperthyroidism, and			

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	155752	A. BUILDING 00 B. WING	09/15/2011

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	peripheral neuropathy. A Physician Order, dated 5/27/11, indicated, "...Accu Check (blood sugar test) AC (before meals) & HS (bedtime)..." Review of the July, 2011, "Diabetic Monitoring Flow Sheet", lacked Accu Check testing for the following two blood sugars and lacked documentation of the amount of coverage given for the following six Accu Checks and one illegible entry: 7/4/11 6:00 A.M. - No testing documented. 7/8/11 6:00 P.M. - Accu Check 230. No coverage documented. 7/14/11 6:00 P.M. - Accu Check 332. No coverage documented. 7/14/11 9:00 P.M. - Accu Check 266. No coverage documented. 7/15/11 12:00 P.M. - Accu Check 198. No coverage documented. 7/16/11 9:00 P.M. - Accu Check 181. No coverage documented. 7/19/11 6:00 P.M. - Accu Check 284. No coverage documented. 7/20/11 6:00 A.M. - No testing documented. 7/24/11 No time documented (4:00 P.M.) Illegible entry.			

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	Review of the August, 2011, "Diabetic Monitoring Flow Sheet", lacked Accu Check testing for the following five blood sugars and lacked documentation of the amount of coverage given for the following two Accu Checks and three illegible entries: 8/7/11 6:00 A.M. - No testing documented. 8/9/11 12:00 P.M. - No testing documented. 8/9/11 6:00 P.M. - Accu Check 292. No coverage documented. 8/9/11 9:00 P.M. - No testing documented. 8/11/11 6:00 P.M. - Accu Check 248. Illegible entry. 8/15/11 9:00 P.M. - Accu Check 338. No coverage documented. 8/17/11 6:00 P.M. - No testing documented. 8/17/11 9:00 P.M. - No testing documented. 8/30/11 6:00 P.M. - Illegible entry. 8/30/11 9:00 P.M. - Illegible entry. Resident # 40's care plan, dated 7/12/11, indicated, "...Monitor BS (blood sugar) as ordered...." Interview on 9/14/11 at 12:05 P.M., LPN # 5 indicated she was unable to read the amount of coverage given for the 8/11/11,			

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	6:00 P.M. blood sugar. She further indicated she is not sure who did it because no one signed it. During interview with the DON on 9/15/11 at 11:05 A.M., she indicated she is now aware of the missing documentation and/or lack of testing. She further indicated she checks the blood sugar monitoring tool for completeness. On 9/15/11 at 11:05 A.M., the Administrator indicated that some of the clinical record entries were unreadable. 3.1-50(a)(1) 3.1-50(a)(2)			
F0516 SS=B	A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Based on observation and interview, the facility failed to ensure unlicensed staff did not have access to closed resident records related to records found in unlocked drawers. This deficiency has the	F0516	F516 – The facility will ensure that unlicensed staff members do not have access to closed resident records and that records are maintained in a safe, secure environments. All inactive resident files prior to 2011 have	10/03/2011

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	potential to affect of the 58 of 58 of closed residents records that were stored in those drawers. Findings include: During an observation on 9/14/11 at 2:50 p.m., Medical Records Employee # 15 entered the office and opened a closet with louvered doors to retrieve some closed records. Three closed records were observed sitting on the cabinets. Inside the closet was one sprinkler head, and in the office were two more. During an interview on 9/14/11 at 2:50 p.m. with the Medical Records Employee #15, she indicated that the closed records on top of the cabinet were recently closed records that have not been put away. She also indicated that those records would not be protected against fire or water. During an observation on 9/14/11 at 2:55 p.m. with the Corporate Administrator and Medical Records Employee #15, the closed records were observed kept behind the facility in a large, two story wood shed in large, metal filing cabinets along with other overflow items for the building, such as activity supplies, dirty laundry to be sent out, decorations, etc. The shed was found unlocked with the key kept in the key box mounted just above the door		been sent to offsite storage. No records will be maintained in the shed. All records have been removed from this location. Current residents records are maintained in the facility in locked fireproof cabinets. Medical Records personnel will ensure that files are maintained in a safe secure environment. Audit of files will be conducted by Administrator or designee at least monthly to ensure continued compliance. Results of audits will be reported to the QA team to ensure continued compliance. Audits of files will be conducted by Administrator or designee once a month. Results of audits will be reported every 3 months to QA committee. The QA committee will review findings to determine if additional audits need to be put in place	

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	handle. The Activities Director and Receptionist #16 were inside the shed accessing supplies. All medical records were found in large locked metal file cabinets. A four foot tall filing cabinet was found to have the two of four drawers unlocked and easily opened. Each drawer contained 29 business files which included the facesheets, date of birth, social security numbers, addresses, and insurance information. During an interview with the Corporate Administrator at the time, he indicated the shed was only unlocked during the day. He also indicated that the closed records found in the two unlocked drawers would not be protected from unauthorized personnel or the general public. During an observation on 9/15/11 at 10:05 a.m. the storage shed behind the facility that contains the closed records was found locked during the Environmental tour. When asked the Maintenance Supervisor used the key inside the key box above the handle to open the lock. The drawers mentioned above were found unlocked. During an interview on 9/15/11 at 10:05 a.m. with the Maintenance Supervisor, he indicated he has had many duplicate keys made because they get lost often. He also indicated that the key is over the lock to			

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	allow employees to access the shed for supplies as needed. The Maintenance Supervisor indicated he was unaware the drawers were unlocked. When asked he indicated the key over the lock would not prevent unauthorized personnel and the general public from accessing the two unlocked drawers with closed records. 3.1-50(d)			